TALL TREE ADMINISTRATORS

Washington County
Health Plan Change Form

Employee Last Name	First Name	SSN #

Section 1 - Change of Employee Name or Address

Change Name From:

Employee's Last Name	First Name	M.I.

Change Address To:

Employee Home Address

Change Name To:

Employee's Last Name	First Name	M.I.	City	State	

Section 2 - Change of Plan Option or Drop Coverage

Drop all coverage for me and any dependents for the following checked boxes:

Medical/Vision	Dental
☐	☐

Effective Date: _____

State Reason for Change: _____

Section 3 - Add Dependent(s)

Dependent(s) are being added to (check boxes that applies)

	Medical/Vision	Dental
	☐	☐

☐ As dependents acquired through birth, marriage, or legal adoption.

☐ As late enrollment

☐ Due to loss of eligibility under another health plan (attach the Certificate of Creditable Coverage from lost health plan.)

☐ Open Enrollment

Dependent's Last Name	First Name	M.I.	Sex	Relationship	(MM/DD/YY)	Social Security Number

 Name: _____

Section 4 - Drop Dependent(s)

Dependent(s) are being dropped to (check boxes that applies)

Medical/Vision ☐ Dental ☐

☐ Because the person(s) listed no longer meet the requirements for being an eligible dependent under the plan, because of age, marriage, or divorce (please explain reason on the back of this form.

☐ Due to becoming eligible under another health plan (name, group number, and telephone number of the other plan must be written on the back of this form, or attach copy of other plan's ID card.)

Dependent's Last Name	First Name	M.I.	Sex	Relationship	Birth Date (MM/DD/YY)	Social Security Number

Section 5 - Other Changes

Are there an other changes you need to make at this time?

☐ Yes ☐ No

If yes, please descibe those changes here: _____

Section 6- Employee Signature (Must be Signed)

I am requesting the changes documented on this form and authorize any required change in payroll deductions.

_____

Employee Signature Date

Office Use Only

Effective Date of Changes by Section #

Section 1 _____ Section 3 _____ Section 5 _____

Section 2 _____ Section 4 _____

X _____

HR Benefits Representative Date